VALTC Frequently Asked Questions
April 9, 2008

BACKGROUND

1. What is VALTC?
Virginia Acute and Long-Term Care Integration, also known as "VALTC," is a program designed to improve the quality of life of Virginia's Medicaid-enrolled seniors and individuals with disabilities by empowering them to remain independent and reside in the setting of their choice for as long as possible.

Currently, individuals who are dually eligible for Medicare and Medicaid, and individuals who participate in the Elderly or Disabled with Consumer Direction (EDCD) waiver are excluded from participating in managed care. These individuals currently receive very little assistance with the coordination of their services – and their services are often very complex and these participants are often very frail.

Through VALTC, dual eligibles and EDCD waiver participants (in certain areas of the Commonwealth) will be able to receive their health care AND long-term care services through a coordinated delivery system. These individuals will be enrolled in a new managed care program that will offer ongoing access to quality health and long-term care services, coordinated benefits between Medicare and Medicaid (for dual eligibles enrolled in the plan's Medicare program), care coordination, and referrals to appropriate community resources.

POPULATIONS

1. What is the EDCD waiver?
The Elderly or Disabled with Consumer Direction (EDCD) waiver is one of seven waivers administered by the Department. The EDCD waiver provides home and community-based services to individuals who meet the nursing facility level of care criteria and are determined to be at risk for nursing facility placement. The EDCD waiver provides community-based care services that enable participants to remain in their homes rather than being placed in a nursing facility. The financial eligibility criteria for the EDCD waiver differ from other Medicaid programs. EDCD participants are the only waiver enrollees that will be included in VALTC.

2. What is a "dual eligible" and will they all qualify for VALTC?
A dual eligible is an individual who qualifies for both Medicaid and Medicare. Not all dual eligibles will participate in VALTC. Only "full benefit" dual eligibles, referred to in regulation as QMB-Plus, can participate in VALTC. Dual eligibles **not** eligible for VALTC include: Qualified Medicare Beneficiaries (QMBs), Special Low Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), or Qualified Individuals (QI).

3. How does a person quality for VALTC?
Only active Medicaid participants who are either dual eligibles, EDCD participants, or both are eligible for VALTC. No other Medicaid participants (including participants in

other home and community-based waiver programs) will be impacted by VALTC. The Department has the final decision on whether an individual qualifies for VALTC.

4. Are children included in VALTC?
No, children (under age 21) will not be included in VALTC. Newborns born to VALTC-enrolled mothers will be covered by a VALTC MCO for the birth month plus two months (a total of 3 months maximum), or until transitioned to a Medallion II MCO, whichever occurs first.

5. Are pregnant women included in VALTC?
Yes, if a VALTC participant becomes pregnant, she will remain enrolled in VALTC.

ENROLLMENT

1. Is VALTC participation mandatory?
Yes, if a participant meets Department criteria for VALTC, and resides in a pilot region, he or she must participate in the program. Limited opt-out provisions exist.

2. How will participants select in which MCO they want to participate?
Dual Eligibles
Dual eligibles will go through a pre-assignment process similar to the Medallion II/FAMIS process. Dual eligibles will receive an introductory letter and a plan comparison chart and will be encouraged to select a plan. If they do not select a plan, they will be pre-assigned to one based on an algorithm. They will then have a 30 day window in which to select a plan.

New EDCD Waiver
EDCD waiver participants will have a separate assignment process. Per regulation, EDCD waiver services must begin within 30 days after an individual is determined eligible for the wavier. An expedited enrollment process is, therefore, necessary. For individuals new to the EDCD waiver, participants will be informed of plan choices when screened for waiver eligibility. If participants do not select a plan, they will be pre-assigned to a plan based on an algorithm. The algorithm is still under development, but will be based on a match between each MCO's network and a participant's recent provider. The enrollment broker will then have three days to contact the participant. If the participant does not make a selection, an official assignment will be made and plans will be notified of the new member.

Current EDCD Waiver
Individuals currently in the EDCD waiver at the time of the VALTC launch will go through a pre-assignment process, similar to that of Medallion II/FAMIS. If the participant does not select a plan, every effort will be made to match the participants with a plan that has one or more of his or her recent providers in its network or with his or her ALTC Phase I MCO, if applicable.

3. Do current EDCD participants convert to VALTC?
Yes, current EDCD participants in the designated localities will be enrolled in VALTC.

4. Can participants change plans?
All enrollees shall have the right to disenroll from the MCO's plan to another health plan, pursuant to 42CFR438.56, as amended, or §1903 (m)(2)A of the Social Security Act, as amended, unless otherwise limited by an approved CMS waiver of applicable requirements. During the first ninety (90) calendar days following the effective date of enrollment, an enrollee may disenroll for any reason. A voluntary disenrollment shall be effective no later than the first day of the second month after the month in which the enrollee requests disenrollment.

Consistent with §1932(A)(4) of the Social Security Act, as amended (42 U.S.C. §1396u-2), the Department must permit an enrollee to disenroll at any time for cause. The request may be submitted orally or in writing to the Department and cite the reason(s) why he or she wishes to disenroll.

5. Will VALTC impact current Medallion II participants?
The only Medallion II participants who will be impacted by VALTC are EDCD individuals participating in Phase I of ALTC. These participants (adults only-age 21 and older) will be moved into VALTC. All other Medallion II participants will remain in Medallion II until they meet the qualifications of an excluded population.

6. How will VALTC impact Phase I of ALTC?
Adult EDCD participants of ALTC Phase I will move to VALTC upon the program's launch. These participants will be pre-assigned to a plan and offered a choice of MCOs. If they do not make a selection, and their current MCO participates in VALTC, they will be assigned to their current MCO.

7. Can participants opt-out of VALTC?
Yes, individuals who enter VALTC who have previously been receiving EDCD Waiver services and for whom enrollment in the VALTC program would detrimentally impact the health, safety, or welfare of the participant may request to "opt-out" (i.e. exemption) from the VALTC program.

All exemption or "opt-out" requests must come from the participant, legal guardian, and/or responsible party and will be individually reviewed and processed by DMAS. Each request will be evaluated by a DMAS Committee on a case-by-case basis to ensure appropriate, accessible, and quality care for the participant. The DMAS Committee will be comprised of staff from long-term care, managed care, and the DMAS Medical Director, as appropriate.

Participants who are non-compliant with the patient pay (see Implementation question #1) requirements in the provision of their EDCD services or with the personal maintenance allowance for nursing facility placement may also be terminated from enrollment in VALTC.

8. What percentage of dual eligibles are currently enrolled in a Medicare Advantage (MA) or Special Needs Plan (SNP)?
As of February, fewer than 5% of dual eligibles were enrolled in a MA plan or SNP.

SERVICES

1. Are all VALTC participants eligible for the same benefit package?
No, VALTC has three separate benefit packages; one for dual eligibles, one for dual eligibles who also participate in the EDCD waiver, and one for Medicaid-only individuals who participate in EDCD. Capitation payments will be based on enrollment in each of these three groups.

2. What long-term care services are available for EDCD waiver participants?
- Adult Day Services,
- Personal Care,
- Respite Care,
- Electronic Monitoring,
- Service Facilitation for Consumer Directed Personal and Respite Care
- Assistive Technology,
- Environmental Modifications; and
- Transition Services & Coordination (offered as a carved out).

Please visit http://websrvr.dmas.virginia.gov/manuals/edcd/edcd.htm for the EDCD provider manual. These same services will be available to EDCD waiver participants when they enter the VALTC program.

3. What is consumer direction?
Participants in the EDCD waiver have the option of "self directing" or "consumer directing" their personal care and/or respite care services. Consumer direction means that the participant hires, fires, trains, and directs their attendant. Consumer directed attendants are considered domestic servants under Virginia law. Please visit: http://www.dmas.virginia.gov/downloads/pdfs/prm-CDS_Comm_Waiv_Manual.pdf for further information.

4. What is a consumer directed fiscal agent?
A fiscal agent is the entity that pays the consumer directed attendant, makes sure that payment is within the approved number of hours of service, and follows all hiring and tax rules on behalf of the EDCD waiver participant as employer of the attendant.

5. **What services are available for dual eligibles?**
Dual eligibles may receive Medicaid coverage for the following:

- **Not included in VALTC capitation rate:**
  - Medicare monthly premiums for Part A, Part B, or both (DMAS will pay Medicare Part A and/or Part B premiums. Premiums will not be included in the capitation rate).
- **Included in VALTC capitation rate:**
  - Coinsurance, copayment, and deductible for Medicare-allowed services (i.e., "crossover claims").
  - Medicaid-covered services, even those that are not allowed by Medicare.

6. If a service is covered by both Medicare and Medicaid, who pays? Medicare always pays first and Medicaid pays the remaining liability- up to the Virginia-allowed amount. Medicaid is the payer of last resort.

7. What services are carved out?
Please refer to Appendix E of the contract for a complete list of carved out services. These services mirror the Medallion II carved out services. Examples of carved out services include community mental health and substance abuse services.

8. Is hospice covered?
Individuals enrolled in hospice are excluded from VALTC enrollment.

9. What will happen to the PACE program once VALTC is launched?
PACE, or the Program for All-Inclusive Care for the Elderly, will remain an option for nursing facility eligible participants who prefer to remain in the community. Individuals cannot be enrolled in PACE and VALTC simultaneously. VALTC participants may opt out of VALTC and enroll in PACE.

PROVIDERS

1. Do long-term care providers have to be licensed?
Currently, DMAS allows non-licensed providers to offer long-term care services.

2. Do long-term care providers have to be credentialed?
DMAS expects MCOs to apply their own network credentialing standards to their long-term care network.

No, as long as long-term care providers meet, at a minimum, the DMAS long-term care provider requirements, credentialing standards and licensing requirements are up to each MCO.

IMPLEMENTATION

1. What is the patient pay and how will this impact VALTC?
Patient pay is the amount of money that a long-term care participant must contribute each month toward the cost of his or her long-term care services. This amount is typically adjusted on an annual basis; however, it can change from month to month in limited circumstances.

The VALTC transition report will include the patient pay amount for each participant. The MCO will assign a provider to collect the patient pay from the participant. In the DMAS fee-for-service program, the provider with the most service hours collects the patient pay from the participant. The MCO will deduct that amount from the provider's reimbursement. Collection of the patient pay is built into the MCO capitation rate. This is different than for co-payments. MCOs must account for this amount.

2. Will DMAS put any extra restrictions on marketing Medicare products to Medicaid enrollees?

No. All marketing and promotional activities (including provider promotional activities) must comply with all relevant Federal and State laws. DMAS is not mandating any additional requirements or restrictions except for the Department approval of plans activities and materials. DMAS, however, does require that plans honor any requests from recipients to "opt-out" of the MCO's marketing activities.

3. On average, how many claims can a MCO expect for VALTC participants on a monthly basis?

	Dual Eligible	Dual Eligible/ EDCD Waiver	EDCD Waiver – Medicaid Only
Average # of Claims per Month	6	15	14

4. What support will DMAS provide to MCOs during ramp-up and implementation?

DMAS will form an MCO Implementation Advisory Group beginning summer 2008. Membership will include representatives from participating MCOs and DMAS staff members. The MCO Implementation Advisory Group will work collaboratively to provide training, clarify requirements, identify challenges, and resolve implementation issues.

Planned topics include:

- Long-term care services- including consumer direction
- Long-term care quality measures
- Dual eligible claims processing
- Screening, eligibility criteria, and enrollment
- Care coordination
- Other topics that the MCOs request

DMAS will also hold training and education sessions for those who will be working on education of participants.

5. What will DMAS do to market VALTC?

This will be developed as part of the VALTC implementation plan.

6. What communication will DMAS have with long-term care providers?

During the falls of 2006 and 2007, DMAS staff met with long-term care providers to encourage their input on the VALTC program design. In March 2008, DMAS sent a letter to current Medicaid providers in the Tidewater area to provide background information on VALTC. DMAS also has a WebEx planned for long-term care providers to provide basic information about contracting with an MCO. In addition, DMAS will hold training sessions throughout the region during implementation. Plans will be invited to participate in selected sessions.

7. When will DMAS launch Richmond?
Richmond is scheduled to launch in late 2009. No other plans have been made for the Richmond implementation at this time.

NURSING FACILITY PLACEMENT

1. What happens if a participant needs nursing facility care?
VALTC participants who are referred by their plans to a nursing facility and meet nursing facility criteria (this does not include step-down care) will remain a member of the VALTC MCO for a period of 60 days. If the beneficiary remains in the nursing facility upon completion of the 60-day period, the beneficiary will be excluded from VALTC and will begin receiving services under the traditional fee-for-service (FFS) program. MCOs will provide care coordination to participants placed in nursing facilities and assist with discharge planning, as appropriate.

The 60-day period is per admission. If a Medicaid beneficiary enrolled in a VALTC managed care plan enters a nursing facility under a Medicare Part A stay, the 60-day clock for continued managed care enrollment will begin upon entry to the nursing facility. The VALTC MCO will be responsible for the Medicaid related costs of nursing facility care during this 60-day period. However, payment for services will be made directly from DMAS to the nursing facility. DMAS will adjust capitation payments to account for nursing facility days.

2. Can a person residing in a nursing facility participate in VALTC?
No. Individuals must reside in the community upon enrollment into VALTC. The only nursing facility participants eligible for VALTC are individuals who were enrolled in VALTC *prior* to their nursing facility admission.

RATES

1. When will we find out more information about rates, cost distribution, and prevalence reports?
VALTC rates, data book, cost distribution, and prevalence reports will be available on April 30 when the final Application for Contracting is released.

CONTRACTING PROCESS

1. What are the key dates of the contracting process?

EVENT	DATE
State Issues Contract	April 30, 2008
Deadline for Submission of Mandatory Requirements	May 30, 2008
Contract Signed and Approved	June 20, 2008
Deadline for Submitting Final Application to the Department	August 29, 2008
Readiness Review Begins	October 1, 2008
Implementation Date	February 1, 2009